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NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
MAI-CoC GRANTEE VIRTUAL MEETING
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>> OPERATOR: Audio recording for this meeting has begun. Hello and welcome to today's teleconference.

>> Hi, everyone, welcome to day two of the MAI-CoC grantee virtual meeting. Thank you for joining us today. I really enjoyed yesterday's content and really appreciate your patience as we work through some of the technical assistance issues.

Today, we have done a couple of things that we think will really help make sure that the audio is working well. So as you may notice, everyone is muted. Also, you want to make sure -- I know we have seen a couple of great discussions in the chat box about how to make sure to dial in with your audio. On the top of your screen towards the left, you should see a phone icon. You want to pull that dropdown menu and the conference line will then call you at the number that you give

it so that you can dial so that the system can call you in. That way, we'll be able to open up your phone lines, especially for those grantees in Regions 4, 3, 2 and 1, the leads who will be presenting.

If you need any technical assistance, please feel free to chat. You can open up a personal chat message with our tech team and they will help you walk through.

So we reduced the audio -- or corrected the audio to make sure that we have lots of muting capacity. We have come up with some new strategies to make sure, it's a nice, smooth process for connecting into your breakout sessions later today. But, again, let us know if you need any help and we will be giving you instructions throughout the session in the different pods to make this as easy and seamless as possible.

I wanted to remind you that closed captioning is available. We had three people ask yesterday. Click on the link in the notes section. The slides will be synced with audio as we go forward.

And at any time, please add a question in the chat box to the presenter. You don't have to wait until the end of the presentation. We'll be kind of going through the questions and curating those if you would, so feel free at any time to add a question into chat box or maybe another Grantee as well as the presenter.

All of today's presentations and resources are available to you if you look at the pod, the file share. You are able to download those now if you want to print out a copy and have those handy when the presenter is going through your slides.

We will also be posting them on the CIHS website, under the virtual meeting tab. You can give the presenters live feedback during the presentation, using the status change button at the top of the screen. You are able to click on the hand icon. And then you can just let the presenter know if you need to address the volume, pace, or maybe simply just react to the presentation.

And lastly, you see here if you have some technical issues, you can email Hannah Coen directly, she will be moderating her email and be able to quickly respond to that.

Again, this is just a reminder, around the computer, you can use your computer mic and speakers for audio. You have two options. Option one, or option two. Do not follow option three. So we'll use -- the system can call you or you can use your computer's microphone and speakers. So, again, let us know if you need any assistance. We will be providing some further instructions for breakouts throughout the day. I'm

excited to welcome and turn it over to Dr. Linda Youngman. She's the branch chief of the division of community programs for the center for substance abuse prevention at SAMHSA so we are happy for Linda to join us and give us some remarks.

>> LINDA YOUNGMAN: Okay. Can I start? Okay. Hello and welcome to CoC grantees. Welcome back to day two. We are pleased to be with you today, and continue our work together on collocation and integration of HIV medical care in the substance use disorder prevention and treatment programs and mental health services. As the person who open, said, I'm Linda Youngman, I'm a branch chief in the center for substance abuse prevention. Many of the project offices in the Center for Substance Abuse Prevention call CSAP are your project officer. We encourage you to connect with your oh, project officers and peers.

I wanted to speak for just a few moments this morning about a recently released national HIV/AIDS strategy. So if you can go to the second slide, please. If you are seeing me on camera, this is the strategy. I put the first page from the new updated strategy on your first slide. And it was just released in July of 2015. So it's very new. Those of you who are familiar with the old national HIV/AIDS strategy, it's the same strategy, but it's been updated to some of the current things that are going on, areas where we can focus our efforts to try and reduce the problems from HIV/AIDS. So if I can go to the next slide, please.

I want to read you to just briefly some of the major indicators. The things that we are asked to work on, to try and make an impact on national HIV/AIDS. First one is to increase the percentage of people living with HIV who do know their Serostatus. So we want to increase that to at least 90%. That means a lot of HIV testing.

The second it to reduce the new diagnosis of HIV/AIDS by at least 25%. That's been an ongoing thing but the government is setting targets where we want to work with grantees to try and reach these changes in the percentages of new diagnoses.

The third indicator is reduce the percentage of young gay and bisexual men who have engaged in HIV risk behaviors by at least 10%.

The fourth is increase the percentage of newly diagnosed persons linked to HIV medical care within one month of their HIV diagnosis to at least 85%. And this is very integral to the CoC program because part of the reason we wanted this program is we want to keep people from falling through the cracks. Lots of times when people have found that they are

positive for HIV, they don't want to go to medical care. They don't want to keep going to medical care and it's really important because what we now know is that people who don't link with medical care, and do keep up with their medical treatment, most of them can live a nearly full lifetime which is great news, indeed.

The fifth indicator is increase the percentage of people with diagnosed HIV infection who are retained in care to at least 90%.

So, again, keeping people from falling through the cracks.

Next slide, please. The sixth indicator is increase the percentage of people with diagnosed HIV infection who are virally suppressed to at least 80%. So these last three, you can see are very much part of the HIV care continuum. Getting people linked to care, keeping them in care, retained in care, so that they become virally suppressed.

The seventh is reduce the percentage of people in HIV medical care who are homeless to no more than 5% what we are increasingly seeing is that people with HIV very often have a whole array of other issues going on and it's really important to help try and turn those around to make sure these people have a stable home.

The eighth indicator is reduce the death rate among persons with diagnosed HIV infection by at least 33%.

So this is the end result of all of those things that we can do to try and get people tested, if they test positive, link them to care, retain them in care, make sure they are virally suppressed and make sure they have a stable home to reduce the death rate.

Part ninth indicator, reduce the disparities in the rate of new diagnosis by at least 15% in the following groups, gay and bisexual men, young black gay and bisexual men, black females and people living in the southern United States.

We have been finding in the southern US, they don't have the kind of help that's offered in some of the metropolitan areas. And that is one 69 groups we want to focus on.

And the tenth indicator is increase the percentage of youth and persons who inject drugs with diagnosed HIV infection who are virally suppressed at least 80%. So those are some of the new things that came up in the update to 2020. This is the update of the national HIV/AIDS strategy that just came out in July 2015.

So if I can have the next slide, please. It's mentioned a little bit in some of the indicators, but I want to reiterate for everyone that this figure comes from the national HIV/AIDS

strategy update, and it shows the high risk groups for HIV/AIDS and what it shows is that the overall rate for HIV/AIDS for blacks was eight times the rate for whites. The rate for black men was the highest of any of the racial ethnic groups they looked at. It's seven times the rate of that of white men.

The rate for black women was 19 times the rate for white women. The rate for Latina Hispanic women was four times rate for white women. So these are groups that we really want to address in our HIV/AIDS programs. This is where we will have the biggest impact on reducing HIV/AIDS rates.

Okay. Next slide, please.

This slide is another way of looking at the same information, and if you look at this, you can see that the following populations are at greatest risk of new HIV infections. Gay and bisexual men, that's always been true. They are very high risk group for HIV/AIDS but also black men and women, Latinos and Latinas and substance abusers. And SAMHSA's CoC program is targeted to all of these high risk groups. I wanted to talk just a moment about substance abuse. It's very much linked to risky sexual behavior. Some of these slides do come from the updated national HIV/AIDS strategy and some of them come from other sources, mostly monitoring the future, the BRFSS, the behavioral risk surveys and the drug use and health.

So in this slide, you can see we have got some good news, actually. Underaged drinking, alcohol use in adolescence, this is showing that in the last few years rates have been going down and that's very good news and SAMHSA has been working very hard to try and address substance use in underaged people.

The next slide shows the same data but from the monitoring the future and behavioral risk factor surveillance system. This focused on binge drinking and it's showing that alcohol use, both binge and past 30 day use is decreasing for use in young adults. So that's great!

But if I can show you the next slide, what we're seeing for marijuana is a different story. Marijuana use is increasing for youth. These are data from the monitoring the futures survey, which focuses on grades 8, 9, 10 and 12. And if you can show the next slide, please.

This is data from SAMHSA's own national survey on drug use and health. And it's showing that marijuana use, particularly if you look at those later years, more recent years, marijuana use is increasing in young adults. So what this means is, even though we've got good news with alcohol, there's worrying news about marijuana and other drugs.

If I can have the next slide, please. In particular, I wanted to highlight what's going on with marijuana use in different ages. What this slide shows you is that about 10% of adults aged 45 to 49 use marijuana in the past year. And marijuana use is lower for the older age groups. So it looks like you see the 40s, then you go down and you see the people in their 50s and further down you see people in your 60s.

So this is maybe somewhat expected, however, what the data also shows is that the use of marijuana is increasing, particularly for people who are older than 50 years of age. And the trend for all age groups is increased use of marijuana. So this is worrying. And if I can have the next slide, please.

This slide comes from the behavioral health barometer, US annual report, it's the 2014 update. And it shows illicit drug use in adolescence. When you first look at it, it looks like it's going down but what I want to highlight for you is the line that's showing the use of drugs in black youth, and drug use is not decreasing for black youth. Again, this is a target group that we need to try to provide help for, and have an effect on risky sexual behavior.

Next slide, please.

So the reason for all of this is that we want to affect the HIV care continuum. The first bar is showing the number of people who are diagnosed. The next bar are those who are linked to care. The next is those who are retained in care. The next is those who are prescribed anti-retroviral therapy. The next is those who are virally suppressed. So each of these bars goes down, and what we would like very much to do, in the continuum of care program, is to up all of these bars so they are as close to 100% as we can get, so that if someone is tested positive for HIV, that they are linked to care. They are retained in care. They get the medical treatment they need, the anti-retroviral treatment, and they become suppressed and hopefully live a nearly full lifetime.

According to CDC, only about 25% of people who are currently living with HIV are virally suppressed. And that's really the whole point of the continuum of care program, is to help increase all of those bars so they are as close to 100% as we can, to keep people from falling through the cracks to make sure they get the care that they need so they can live a full life.

So last slide. I just want to thank you for your time today and for your dedication to providing integrated substance abuse care, HIV medical care, and behavioral healthcare to those most in need.

And please contact any of us at SAMHSA, if we can help you to make your CoC program a success. That's why we are here. If we can answer questions, if we can help you with problems that you are having, to try and help you make your program a success, that would be great.

And I would be happy to answer any questions.

>> JAKE BOWLING: Thank you so much, Linda, for those remarks. At this time, if the folks would like to type any questions in the chat box, we would be glad to share those with Linda.

All right. There are no questions coming in at this time, but feel free to enter your questions throughout the day.

At this time, I'm going to turn it over to Kelly Wagner, from the Maya Tech Corporation. Kelly, can you hear me?

>> KELLY WAGNER: I can hear you well, Jake. Thank you. Good morning or good afternoon to everyone, depending on what region you are in. As Jake mentioned my name is Kelly Wagner. And I am with the Maya Tech Corporation. We are part of the team providing technical assistance to the MAI-CoC program. What I would like to do is moderate the grantee mini updates from Regions 4, 3, 2 and 1, and then once we finish those four regions, we will open up the line to anyone that we may have missed yesterday.

So I'm going to start with Region 4, and ask if the representative from health services center in Anniston, Alabama would be able to provide a two-minute update on your MAI-CoC project.

>> JAKE BOWLING: So if the person from Health Services Center could use the raise your hand function. That way our host will know which line to unmute.

>> Can you hear me?

>> KELLY WAGNER: I can hear you.

>> I'm behavioral health counselor with Health Services Center in Alabama. Our grant is behavioral health collocation, and we are unique because we provide substance abuse services to individuals with co-crane disorders in two communities that are in rural Alabama. Due to the nature of the rural communities that we serve, we provide van rides, and other transportation because there's no consistent public transportation in our area.

Some communities have buses and the community five miles down the road has nothing to offer. So we are able to do that uniquely. Additionally we also provide substance abuse services over the phone for people who are so far out where we can't even get to them on a regular basis or have limited

availability.

Additionally, we are unique because our prevention staff partners with local health departments, community events, and we are also the only agency in our 14 county service area that provides HIV and hepatitis testing and education.

Thank you.

>> KELLY WAGNER: Thank you very much for your update.

We are going to move to Florida right now and ask that the represent from Coastal Horizons Center use the raise your hand feature so you can be unmuted. Jake, have you seen a hand raised for Coastal Horizons Center yet?

>> JAKE BOWLING: I have not. So feel free to keep moving down the list, and we can come back to them if we see or hear anything in the chat box.

>> KELLY WAGNER: Okay. We will move to the Tampa area of Florida and ask that the representative from the Drug Abuse Comprehensive Coordinating Office, please raise your hand to be unmuted.

>> Hello?

>> KELLY WAGNER: We can hear you.

>> Perfect. My name is Bernice McCoy, I'm the health services manager, and I'm speaking on behalf of Alice Prendergast who is our health services coordinator and Andrew McFarland our director and Bobby Davis. It's the integrational medical care and behavioral health. We are a collocated site with Tampa Family Health Centers on site which is a federally qualified health center, we are FQHC. For the purposes of this grant, our target population is that of ethnic and racial minorities.

We predominantly serve substance abusing individuals who are at high risk or positive for hep C and HIV and people with collocation, such as mental health issues. And some include hep C and HIV testing and we do have substance abusers that have varying level of cares, with detox and outpatient services for men, women and adolescents and special populations which include pregnant women, and individuals who identify as MSM or LGBTQ. We feel one of our greatest accomplishments thus far, it's interesting in this grant, is that it has really allowed us to provide integrated healthcare and we pride ourselves in being a one-top shop for primary healthcare and social services for the Tampa Bay community. We are very proud that we can expand those services into rural areas, which include Wimauma and Rustlin area that have been populated with undocumented areas.

>> KELLY WAGNER: We will loop back to the coastal horizons

center. I have been given word that someone there has raised their hand.

Okay. We will check back in with coastal horizon centers again.

Is someone available from River Region Human Services in Florida? Please use the raise your hand feature so you can be unmuted.

Okay. We are going to keep moving down the list to --

>> I'm here.

>> Oh. Regina from Coastal Horizons.

>> Oh, okay, Regina, take it away.

>> Thank you. Operator error. I was muted on my end and I couldn't undo it.

I'm Regina Penna and I'm the continuum of care coordinator for Coastal Horizons Center. We are in southeastern North Carolina on the coast. We cover three counties New Hanover, Pender and Brunswick Counties. New Hanover is the urban center around here. We are about 200,000 people. And then Pender and Brunswick County are outlying counties for us and they are very rural. We have a large migrant worker population out there and just a lot of the other issues that rural areas face with transportation, stigma, lack of services. We are collocating services right now and trying to integrate them into our own system, coastal horizons about 45 years old and we are a behavioral health providing mental health and substance abuse treatment. We are 45 years old here in the area.

And we are currently integrating primary care and testing into our own population. Some of our accomplishments so far, we have been able to establish the first satellite HIV clinic in one of our surrounding counties and we are looking to -- we are meeting there once a month along with some of our community partners. We have community partner agencies with our hospital, which provides HIV medical treatment for people, and then we have several case management organizations in the community. Our staff provides mental health services for people who are in care, and we also provide support groups which have been sadly lacking in our community as well.

We are trying not to recreate services that are out, there but just bring together in a safety net those that are out there. So our partners were very pleased that we were able to do -- to establish the first clinic in Pender County a couple of months ago and we are hoping no establish one in Brunswick later on in the fall. There has some construction that's going on there.

Our opportunities for growth are, once again, truly

integrating our healthcare model into our own population here, with our current clients and then expand outwards. One other thing that we have had the opportunity to do, which has been sorely needed is to bring together the medical community in the -- in southeastern North Carolina to try and develop a local clinic model for hepatitis treatment.

The majority of clients who are HIV positive have been referred to -- previously have been referred to Chapel Hill, to the Liver clinic up there for treatment and that's about two hours away. If you are talking about communities that have transportation issues, it becomes very prohibitive for them to get to Chapel Hill. So we have been convening this local clinic model to try to help providers to see what we can do locally here, before we have to send people out. So that's been a true boom for our project here.

And that's about it.

>> KELLY WAGNER: Thank you, Regina.

Maria from River Region Human Services, are you unmuted now?

Okay. We will circle back to you.

Is someone available from HIV/AIDS Empowerment Resource Center for Young Women?

Okay. We have a hand raised and, you should be unmuted.

>> Hello? Hello?

>> KELLY WAGNER: Hello.

>> Hi.

>> KELLY WAGNER: Who is this?

>> Can you hear me? My name is Liddy and I'm a program manager at HIV/AIDS Empowerment Resource Center for Young Women, also known as Empowerment Resource Center. We are located in Atlanta, Georgia. The name of our program is integrated care partnership of metra Atlanta, best known as ICP and for this grant we have partnered with absolute care an Tangu Incorporated to provide services to our target population.

So our target populations are undeserved hard to reach and vulnerable minority and ethnic societies in Atlanta. It's to prevent HIV and medical care services and fully integrate linkage and referral systems between direct care providers. And it's been a really good success as far as our program because we have been able to provide an infrastructure that builds capacity among collaborators to coordinate a comprehensive opportunity of care living at risk for risk of HIV and AIDS through practices. To date we have reached over 50% of our target and I realize that someone had mentioned this before, but recruitment is not an issue, however, retention has

been a challenge for us.

So we have actually been looking with -- to our partners as far as ways we can overcome that. But we have been fortunate that individuals may not meet our eligibility criteria for our program, we have other program services offered for them here on site. And that is all.

>> KELLY WAGNER: Okay. Thank you so much for the update.

Is someone available from Positive Impact in Georgia? Please use the raise your hand feature.

>> Hello?

>> Mynetta. Hi, this is Mynetta Sinclair. How are you.

>> KELLY WAGNER: We can hear you.

>> Our new name is positive health center impact. The name of our project is FUSE is which facilitating unified service efforts. We are a private nonprofit community-based AIDS service organization, and we -- following a merger, a strategic merger in March of this year, we now have two clinics in Midtown and Duluth, and we serve adults 18 and over in 20 metro Atlanta counties. We test individuals that are 16 and over. We tend to service marginalized populations affected by HIV and AIDS, which includes primarily African-Americans and Latinos and Hispanics, MSMs, substance abusers and the homeless.

Historically, positive impact, behaviorally focused prevention services for over 20 years and who we merged with, provided HIV primary care and prevention services for over 20 years as well. The level of integration for our services with this grant award, we were -- we collocated and integrated HIV primary care and plan to further integrate mental health assessment. The client center HIV primary care in the area is overwhelming and we have had to place restrictions on enrollment to manage the caseloads. We plan to expand gradually throughout the grant period to continue to build capacity.

I think -- there are several things that make our project unique is that we already had the strong collaboration with AIDS Gwinnett. We also addressed all levels of diction through risk reduction, a license intensive outpatient treatment program and continuing care.

And I think one of the most unique things about us is not only can we provide testing, HIV and the HepC and vaccination but we have a 7% positivity rate which is significant because the national average is less than 1%. I think this indicates that we are reaching some of the populations most at risk for HIV infection.

That's all.

>> KELLY WAGNER: Okay. Thank you very much for the update.

Is someone available from recovery consultants of Atlanta? A couple of hands raised?

>> Hi. Can recall hear me now?

>> KELLY WAGNER: We can.

>> This is Maria Rodriguez from calling from River Region Human Services.

>> KELLY WAGNER: Okay. Then we are looping back with you.

>> I am so sorry.

So as I said before, my name is Maria Rodriguez, I'm the program manager for Intact here at river region. River region has been around for about 40 years plus. And the Jacksonville, Florida, Region. We cover other counties around, like the Baker County, Clay county, Duval and Nassau Counties as well. We provide services and primary areas. One of them being substance abuse, mental health, housing, youth and family services, and outreach and community services.

Our grant is specifically targeted to adult African-American male and females both gay, lesbian, bisexual, as well as straight, and it is to provide them twofold -- two primary services. Primary care, as well as mental health and substance abuse. We are collocated integrated. We also provide peer services. We do outreach in the community. We do -- we do groups and we do all kinds of classes. We have a couple of case managers on board.

So we are a wraparound one stop shop. I know you have heard that word more than once already from other grantees, but we do provide a one stop shop approach to healthcare and wellness.

And I think what sets our project apart a little bit more is two things, two primary things. We do have very strong peer component and our peer is using a couple of evidence-based practices to help engage our members. One of the practices is Shield Self help in removing life threatening diseases. We are about to graduate our first cohort of individuals who are now trained as peer educators who will help place in the community to volunteer and continue to reach out and educate the community.

The other evidence-based practice that we are using is the wellness recovery action plan and that's targeted to people who are in recovery and we use recovery in a very broad sense, both from substance abuse and mental health or any other life challenges.

And so we encourage people to come in and set up a tool that they can use and tweak to help figure out how to target their recovery in different ways.

And then the other aspect that sets us apart is the fact that we use the club house model approach to our clients. So everything that we do is specifically driven by our clients and we try to meet everybody where they are at.

And that's pretty much it. That's where we are right now. Very exciting place. This is our first year in operation.

>> KELLY WAGNER: Thank you Maria.

I will go back to recovery consultants of Atlanta. I think I saw a hand raised earlier for being unmuted. Cassandra, are you unmuted? Hello?

Okay. We are going no move on to the next grantee. Can someone from St. Joseph's Mercy Care Services please raise your hand to be unmuted.

>> Hi, are you hear me?

>> KELLY WAGNER: We can. Thank you.

>> I'm Emily, I'm calling from mercy care. We serve primarily homeless and uninsured patients. We are a federally qualified health center, and we just recently gained patient-centered medical home status, which we are really excited about. We have 14 clinic locations, five of which are mobile locations. The rest are permanent clinics, either inside of a partner agency or standalone clinics and this grant is primarily housed in our main downtown location.

We have been an integrated clinic primary to this grant, and provided integrated medical, behavioral health, substance abuse and case management services, but what this grant has allowed us to do is really expand upon our HIV and hep C services. We have a dedicated health service specialist for the HIV clients, as well as a dedicated substance abuse provider who provides outpatient substance abuse services in groups and we do have some partners in the community for higher level of care needs for substance abuse.

And we're just really excited about what we have been able to do so far.

>> KELLY WAGNER: Okay. Emily, thank you very much.

We are going to move into Region 3. I'm going to loop back to Cassandra in a second. Can someone from Brandywine Counseling and Community Services please raise your hand to be unmuted.

>> Hello.

>> KELLY WAGNER: Hello.

>> My name is Nicole White. I'm the project manager of Project Community Outreach and Prevention at Brandywine. We provide a wide array of services for addiction and mental health and all levels of prevention and treatment. Specific to

the continuum of care grant we are offering intensive care and providing resources to help them take control of their health and wellness. The COPE program is integrated and collocated. We have an in-house infectious disease clinic which helps to treat our HIV and hep C clients. And it provides free health screenings to those in need in rural and urban settings throughout the state of Delaware. We take the RV to sites throughout state to provide blood glucose, and blood pressure screenings, among other things and based on our findings we provide the appropriate linkages to care and treatment, as well as follow-up.

My favorite part of this program is seeing the direct impact we are having on our clients. We are getting people into life-saving treatment programs and in addition to getting people care for their HIV and hep C. They are have eye care and dental care and coordinate hip replacement surgery for a client who suffered in chronic pain for years and just encountered too many systemic barriers. These are the success stories that we are really holding on to and we are very thankful for the opportunity to provide those services under this grant. Thank you very much.

>> KELLY WAGNER: Thank you, Nicole.

From someone from the University of Maryland Baltimore raise your hand to be unmuted? Wendy, are you unmuted?

Okay. We will loop back to Wendy.

And now we are going to move to HHS Region 2. Can someone from Albert Einstein College of Medicine raise your hand to be unmuted, please?

Is anyone unmuted at this point in.

Okay, we will move down the list. Can we move to Bridging Access to Care raise your hand to be unmuted.

>> Hi. This is Kathy. My name is Kathy Holitz. We're calling in from Bridging Access to Care in Brooklyn, New York. I'm project manager of wellness together. I'm here with the project director, Eileen Sunshine. So as I said, we are operating out of Brooklyn, New York. We have two clinics that we are offering both integrated and collocated care. At our substance abuse clinic, we are offering integrated care and we are serving -- we are serving individuals who are living with HIV/AIDS and also co-occurring substance abuse problems at our mental health clinic in Williamsburg, Brooklyn. We are collocating. We have doctor on site one day a week to provide medical care to our clients.

So we have -- I mean, we have had a lot of success so far. Clients -- clients have demonstrated that they are more engaged

in their medical treatment, as well as their behavioral health treatment because they are getting more personalized service and specialized case management to help them. We are providing rapid testing for both hepatitis C and HIV. We have tested two new positive -- newly positive HIV individuals and connected them to care immediately, one of our substance abuse and one in our mental health.

So we have had success with that.

We use three evidence-based practices motivational interviewing, a health belief model and contingency management, which has helped definitely in the retention of our individuals enrolled in the program.

I think that's about it.

>> KELLY WAGNER: Okay. Thank you, Kathy. I'm going to check back in with Cassandra. Can you raise your hand? And let's see, Wendy?

Okay. We'll come back.

Is someone available from Community Counseling and Mediation in New York?

I saw a hand raised a minute ago. Okay. We'll loop back to Community Counseling and Mediation.

Is someone available for Services for the Underserved?

Okay. We are going to continue to move through, VIP services vocational instruction project?

Dana? To be unmuted.

>> Hello.

>> KELLY WAGNER: Hi, Dana, are you there?

>> Hi, this is Alicia, project manager. How are you?

>> KELLY WAGNER: I'm doing fine.

>> So I'm from the community services in the south Bronx, and our target population is adult men, women, and LGBT who identify as African-American and Hispanic, Latino, who they primarily reside in the Bronx. The population, they may have trauma history, disorders and homelessness. The integration project is integrated within VIP community services which makes it very unique. We are a true one stop shop with behavioral health. And it's in the inpatient and the outpatient substance abuse offices, including opiate services, mental health and housing projects. We provide evidence-based group and expert screenings along with HIV and hep C education and testing. Via our care coordination, we have medical access in two major hospitals and soon to be four by the end of the year.

One of our accomplishments is the integration and the vocational coordinator has managed to incorporate all the VIP programs, including providing outreach and service to our Bronx

community population. We successfully had 11 participants complete the recovery training and expanded vocational opportunity to our population. We have -- we also have developed an interdisciplinary agency, with support, but benefits the clients to have you will at clinicians working with them on the same page. We also have five peer recovery navigators that provide amazing service, and meet the clients where they are. We believe there's no wrong person, any client can have access to the project, through any entity within the VIP community service which is excellent in terms of enhancing retention to care.

We have -- we also have a unique program that can serve a client with one service and assist with other services via the warm handoff delivery which sometimes is problematic and keeping retention, sometimes we refer a client and they don't make it there. So that warm handoff is good and unique for us.

Thank you.

>> KELLY WAGNER: Thank you, Alicia.

I'm going to move on to Wendy now, it looks like we might be able to get Wendy unmuted.

>> Okay. Can you hear me now?

>> KELLY WAGNER: We can.

>> Thank you! Thank you for working with me. My name is Wendy Potts and the I'm the project manager representing the University of Maryland, stir it initiative. Our stir it stands for screening and testing for HIV and hepatitis immunization for hep A and B and integrated treatment services.

Our population is African-American men and women, who are at high risk for HIV and hepatitis and those who are seeking -- as well as those seeking psychiatric care within the University of Maryland, Baltimore city community mental health clinics. The stir it project, just very quickly has multiple visits that are approximately 20 minutes in length, with a STIR nurse over a six-month period.

In addition to using the STIR nurse we also have peers like some of the other projects were talking about who identify as hepatitis and HIV positive. One thing unique about our project is a few years ago we conducted a similar STIR project and at that time, we are able to get a fabulous seasoned nurse who had mental health and substance abuse experience and when this project came around again, by some -- someone helping out with us, we were able to retain her once again. Rose has been wonderful. She was able to retain a 97% retention rate. We hope that we can continue to do the same, if not higher doing a similar project and now having the integrated services all on

campus. So that's our project.

>> KELLY WAGNER: Thank you, Wendy.

And we will move to -- is someone available from Whitney M Young, Jr., health center?

Okay. I hear someone.

Okay. It sounds like there's a mic problem. Hopefully if you are having technical challenges please type a message in the chat window and I'm going to move on to Yale University. Someone from Yale, use the raise your hand feature to be unmuted. I think I see Ruth Ann.

>> Can you hear me? Hi, this is Ruth Ann Marcus. I'm at Yale University in the AIDS program, and our project is called project Mcharts and that stands for mobile collocation of HIV-related activities with resources and transitional services. And we are providing quality of life for those who are at risk for HIV or hepatitis C, who are homeless and who experience mental illness or substance abuse difficulties.

We are working with our -- we have a community healthcare van, a mobile medical clinic that provides primary care, HIV and hep C prevention and drug treatment programs. Primary care would include primary medical care, blood pressure checks, glucose screening, pregnancy or STI testing, TB screening and linkage to services, as well as hepatitis screening and vaccination.

We do HIV and hep C rapid testing, and we do drug treatment. One of things that's unique about our program is that we are using our substance abuse counselor and our psychiatric APRN do psych and mental health evaluations and provide extended release naltrexone for the use of substance abuse disorders. So we have the activities that are on our community healthcare van and we are partnering with a housing provider called Liberty Community Services. They are the largest Hopwell funded agencies in the New Haven, Connecticut, area. They have hired through this program, network and peer navigators to work with people on housing, identifying housing needs, helping people find housing and working with these peer and network navigators.

The other thing that is different about our program is that we facilitate access to housing for people who are transitioning from jail or who are at risk for reincarceration. So we are actually also partnering with the Connecticut department of correction which is one integrated correctional system, where, you know, the department of corrections the jails and the prisons and we have somebody who is a referrals coordinator within the DOC who works very closely with us on

our team and identifies people who are coming back to the New Haven area who would be eligible for this project, who are in need of housing who have mental health and substance -- mental health or substance use disorder and at risk for HIV.

We are collocating our services by having the people who work on the community healthcare van also spend some time over at the housing agency, providing mental health and substance use treatment and counseling. I think that's pretty much it.

>> KELLY WAGNER: Thank you, Ruth Ann. I will circle back to some of the people who were having challenges with unmuting. I will ask if Dalveer is available. From Community Counseling Mediation.

Okay. We will check on Cassandra from Recovery Consultants of Atlanta.

Ah Cassandra's hand is up. Can she be unmuted? I hear someone on the phone is that Cassandra?

>> Yes, can you hear me.

>> KELLY WAGNER: Yes, we can.

>> Good afternoon, I'm Cassandra Colins the project director for the Recovery Consultants of Atlanta. We provide integrated services of collocation, and HIV medical care within Fulton and DeKalb Counties. Our target population includes African-American adult men who have sex with men, and heterosexual men and women who are substance users or who engage in other activities that put them at risk for HIV.

Our medical partner includes AIDS Healthcare Foundation and Grady clinic. A major accomplish. Has been that we have been able to effectively reach our target population through outreach, being able to both conduct HIV, hepatitis testing, as well as link individuals needing treatment to both detox and our outpatient and residential treatment programs.

One the things that I would say that is unique with Recovery Consultants of Atlanta, we use an array of recovery support services to assist individuals in retaining them in care, as well as sustaining their recovery and those include both housing, transportation, employment and training.

>> KELLY WAGNER: Okay. Thank you, Cassandra.

>> Thank you.

>> KELLY WAGNER: I'm going to check and see if someone from Albert Einstein College of Medicine is available.

Okay.

I'm going to loop back to Aaron from Services for the Underserved.

For -- if you have been having challenges connecting, there were instructions that were sent to everyone in the chat

message box. I think Erin and Dalveer to call, the 1-800 number that was put into the chat box and the numbers to enter when prompted.

Is anyone from Whitney M Young Junior Health Center available?

Okay. If you are having computer issues, connecting please call 1-800-832-0736 and then when you are prompted, enter 348-2060 and the pound sign. I'm sorry, there's a star prior to the prompt. So it's star 3482060, and then pound.

>> JAKE BOWLING: Hi, Kelly, I wonder if we can open up Dana Coleman's lines. She has a raised hand. Dana, are you with us? Dana, Dalveer or Erin, is anyone on the line?

>> KELLY WAGNER: Okay.

It looks like the last three presenters that we are still having some technical challenges. Oh, they are dialing in now.

>> Good afternoon.

>> KELLY WAGNER: Ah!

>> This is Brenda Whittaker from Services for the Underserved.

>> KELLY WAGNER: Thank you for joining us.

>> Thank you. We finally -- (no audio.) we have Erin who has been trying to get us in. We are located in Brooklyn, New York and the name of our project is project health. And that stands for health, education, assistance, linkage, treatment, and hope.

We are integrated service. We are located in what we call the recovery center, which houses a mental health clinic, a club house, and employment services. The individuals that we serve or individuals with mental health or substance abuse disorders who are at risk or living with HIV or hep C. And this includes African-Americans, Latino, gay, bisexual, transgender, and substance abuse users.

Since we are an integrated and not collocated, we have partnered with downstate for hep C and HIV services and Interfaith Medical Center for HIV and medical care and Mount Sinai for HIV, hep C and medical care. We did have a slow start, but despite that, we have been able to conduct 145 tests with 7% of those being positive. Of those who have tested positive, seven have been linked to care and three are in the process and we are very proud of the fact that we were able to link these individuals to care.

We currently have 34 individuals that are enrolled into our project, and they are receiving care coordination and evidence-based practices such as respect, peer support, patient navigation and we also do prevention counseling and health

living groups from a wellness perspective. And that's where we are now.

>> KELLY WAGNER: Okay. Thank you so much. I'm going to do another check in with Community Counseling and Mediation.

>> Hello. Hello. It took quite a while. Sorry about that.]

My name is Delveer. We are based in downtown Brooklyn and we are a CBO that provides mental health and substance abuse services to predominantly high need individuals in the Brooklyn area. The project has -- it's definitely been a challenge but we have done well so far. We conduct testing on site and mobile, and we do rapid HIV and hepatitis C testing. And we also do hepatitis B testing on site. We are integrated models and we work with SUNY downstate. To date, so far we, we have been able to test 142 individuals and been able to get five people into care with HIV for SUNY downstate and care for hepatitis treatment. We have also worked quite a lot around substance abuse and we have in our own substance abuse prevention program, we have referred three brand new clients literally in the past month. So it was a challenging start, but definitely, there's a need for this.

I think our biggest challenge right now is to -- is to work with the homeless community, and there's a huge homeless community that we work with. But, yeah. That's where we are right now.

>> KELLY WAGNER: Thank you, Delveer. We are very excited that you made it through on the audio.

>> I know, right.

>> KELLY WAGNER: I will check back in with Albert Einstein School of Medicine. And then I'm going to check back in with Whitney M Young, Jr., health center. It hooks like Claude yeah vega said that she's here. Not sure from which organization. But Claudia, if you are still having challenging getting in, you can dial the 1-800 number, which is 1-800-832-0736, and then when prompted, enter star 3482060-pound. Give Claudia a second to see if she can connect.

I think I hear something. No one on the line?

>> JAKE BOWLING: Kelly, this is Jake. I would recommend if you want to move forward with the program, we will reach out -- oh, Claudia just typed in that she's here. So maybe we can get Claudia vega's update after all. Claudia, are you on the line?

>> KELLY WAGNER: I think she's trying to get in.

>> JAKE BOWLING: We will see if we can get the update from Claudia the recruitment and retention portion. We will work

with her to clean up her audio issues.

>> KELLY WAGNER: We apologize for the technical difficulties for those grantees that were not able to get in through the audio and hopefully we will be able to follow up with you and be able to get -- oh, wait a minute. Warya.

>> Oh, I'm sorry. I'm up from Region 10. I'm not on the list, and so I thought maybe you are moving on.

>> KELLY WAGNER: Did you do a presentation yesterday?

>> No. Region 10 was not on the list for yesterday and 10.

>> KELLY WAGNER: Well, then we truly apologize for that and you say we are ready for your update.

>> Okay. So my name is Wayra. I'm with Neighborhood House and my project is called Project d handle. It's an HIV and as a neighborhood health. We collocated our program for this proposed brand at Navo to form a Project Handles and our other partner is King Tut public health and Navals provide mental health and substance abuse treatment. And it provides HIV and hepatitis C services as well as the substance abuse prevention and then King County public health provides services for the HIV positive or the hepatitis C positive clients. Our population are US and foreign important African-American and foreign born. We focus on the foreperson born population from East Africa. So we have staff that speaks Swahili. That's one of the uniqueness of our programs. We have tested over 100 people since we started and there's a lot of opportunity of growth in our programs in terms of serving not just East Africans but also homeless individuals as well as veterans. So we're very excited about that. That's it. Thank you. Can you hear me?

>> KELLY WAGNER: Yes. Thank you.

That was an update from Seattle, Washington, correct?

I believe that Claudia is on the line and should be unmuted now.

>> Hello. Can you hear me?

>> KELLY WAGNER: We can.

>> Oh, I was having server problems and I couldn't catch the whole number. It was awful, but here I am. Thanks for your patience. So my name is Claudia Vega and with Whitney Young Health Center in New York. Our program is called upbeat. Which stands for uplifting patients bridging engagement and treatment. We provide services to African-American folks and Hispanic and Latinos and other minorities, who have substance abuse or mental health or co-occurrence of substance abuse and mental health and who are living or at risk of HIV and hepatitis C.

We integrate mental health, behavioral health and primary care to this population, and we are collocated with Whitney Young's methadone clinic and another outpatient substance abuse clinic as well. So we're able to really integrate with already existing services and provide the full gamut of services that the patients need.

We will also be working with Equinox in the next few months. They have a mental health clinic and we will be providing our services to them. So connections to HIV primary care and antiviral therapy treatments and case management and connections to mental health services, peer-to-peer groups and we are doing HIV and hepatitis C rapid testing as well.

It has been hard for us because we -- we couldn't get the approval to start up the primary care and in the collocated -- in the location where the methadone clinic was, but we finally got the go and so in the past few months, we have been really getting people involved and getting them tested and we're doing okay. So that's my update. My update to UPBEAT.

>> KELLY WAGNER: Thank you very much, Claudia. Is there anyone that we missed yesterday?

Okay. Well, thank you to everyone that participated. Is someone knocking to enter the room?

I just want to say thank you to everyone for doing a wonderful job in your communities and on the updates I'm going to transition to the next session on our agenda. We have a number of remarks around recruitment and retention in the era of the Affordable Care Act, and I would like to introduce Mr. Bill Hudock who is with the mental health services here at SAMHSA.

>> WILLIAM HUDOCK: All righty, thank you. Good afternoon, everybody. I recognize it's been a -- probably a long day so far, but the reality is this is important work. So consequently, it's worth our time.

Why don't we go to the next slide. What I will do is talk about the Affordable Care Act and I know that all of us have been through this, probably 100 times. You know, we have heard it called Obamacare. We heard it called, you know, any other number of things, but the reality is that there's been more heat than light in the way in which it's been explained. And therefore, I'm going to very, very quickly go over what the Affordable Care Act does, and then talk about what are the implications for the work that you are doing, and in particular, get into what will and will not be funded looking forward because these, I think are going to be issues that are

important for your retention and your enrollment functions.

Yep.

Okay. So first of all, the Affordable Care Act does really six major things. First of all, it does insurance reforms. Secondly, it establishes a floor for insurance policy benefits. And the bright spot there is that it's somewhat more comprehensive than a lot of the care that had existed around the country previously.

Thirdly, it establishes the requirement that everyone have insurance along with subsidies to make the purchase of insurance more affordable.

In that regard, I think it's important for us to recognize that there's a contentious issue about noncitizens, and for that reason, noncitizens are really not covered by the Affordable Care Act to any large extent, and we'll get back to that a little bit later.

Fourth, we create changes in how medical benefits are reimbursed, and that's going to be important, both in terms of looking at quality of care and what we are trying to accomplish in terms of comprehensiveness of services. Fifth, it fosters the adoption and use of electronic medical records which are designed to really help integrate care and lastly, it actually fosters the organization of providers to, again, better integrate care.

May I have the next slide, please.

Okay. For insurance reforms, the key ones that are important from our perspective is there no longer can be preexisting limitations on coverage. What that means is that previously if somebody had been diagnosed with HIV, oftentimes anything related to that HIV coverage would not have been covered under their insurance that they purchased after that time. That provision now preexisting conditions can no longer be used for limitation of coverage.

Also, there could be no cancellation of coverage from being ill, and that was a previous problem. Third, there's an automatic right to renew coverage or purchase from available coverage each year. It's an open enrollment period that occurs in the fall for the next year.

Fourth, there's no change in rates, other than for age and for tobacco use. And we recognize the fact that the co-morbidities here of the use of tobacco products are high and that can make insurance unaffordable.

Fourth or fifth, there's plain language requirement, so people can understand their benefits. There's streamlined enrollment which allows you to enroll for both privately

purchased and Medicaid at the same time, and lastly, minimum insurance benefits.

For minimum insurance benefits, the key thing is that there's a required essential benefits and for our purposes, there are three that are important. One is that it requires that new policies include a mental health and a substance use disorder benefit where previously those were optional. Secondly, that a pharmacy benefit has to be covered and third, that both rehabilitation and habilitation services have to be covered. What that means, basically, is that you have to provide all the benefits that are helpful to get people back into work and get people back into being productive.

Benefit levels are based on the most common insurance plan in each state. What this means is very important. It means that each state will have a different minimum benefit. And if you are living in Mississippi, it's going to be fundamentally different than it would be in Massachusetts.

The next thing is that prevention services are available at no cost to the individual. The key one from our perspective are depression screening, a SBIRT which is a treatment for alcohol and smoking cessation.

Minimum insurance coverage must be purchased or a fine would be paid. This is the requirement if you will that each individual have coverage. There are exceptions for very low income people in non-medicated expansion states. Now there are 20 states that are not expanded Medicaid at this point in time. You probably know which ones they are. So at that point in time, there are some people who fall through the cracks. Those people are very important because they then can be covered by grant funding.

There's certain religious groups who have an exemption under the law, and also people who are currently in state or federal institutional care, that includes prisons, jails, as well as state hospitals, do not have to have coverage.

Medicaid, Medicare, VA, Tri-Care, and Tri-Care being the coverage for people in the military, and -- oops. If you could go back a slide, please.

Thank you.

And employer-based coverages all apply for meeting that minimum requirement and then the employer mandate exists also to provide coverage for anybody working over 30 hours a week. There are subsidies on a slide scale for those who are between 100% and 400% of the federal poverty level, and Medicaid can be expanded to 138% of the federal poverty level for those states that choose to do it.

Now, what this does is creates an issue, though. For those states that have not expanded Medicaid, you can have the individuals who can be making as little as 20% of the federal poverty level, who are not eligible for any coverage, and because they don't make a minimum of 100%, they actually are not provided subsidies by the federal government either. This is a problem that they have in the non-Medicaid expansion states.

Next slide, please.

Okay. Some of the implications of this also are that you have a change in reimbursement of services. And this is important for a provider agency such as yourselves because there's going to be a movement, and this is occurring right now heavily on the medical surgical side, but will be coming to the behavioral health side over the next three to five years. One is there's a movement towards purchasing bundles of services rather than individual services. And what that means is that you will be able to have more comprehensive service bundles that are provided for individuals. Secondly a movement towards paying for quality, rather than quantity. And therefore, the issue is going to be whether you are able to demonstrate the quality of the work that you are providing for people.

Third movement towards paying for outcomes rather than for procedures. This becomes important because we are going to have to look for how well are we able to stabilize people who have HIV? How will are we able to get their virus loads in check? All of that and you will be paid on outcome produced, rather than just the work to create that.

Lastly, a movement towards not paying for rehospitalizations and we see that right now for hospital acquired infections. We are seeing it also for other types of medical procedures. This is something that virtually all private payers and public payers are moving towards. The impact is there for -- it's going to be less federal and state grant funding of medical care. At assumption is that medical care is that if it's covered by insurance does not need to be covered by grants.

Next slide, please.

There's also at forwardable care act is fostering changes on how care is organized and managed. The first thing that you have I'm sure heard a lot about and probably been involved with is the introduction of electronic medical records so that you can share the medical history and treatments that are being provided amongst all of the providers involved in someone's care. Also we are hooking at patient-centered medical homes which provide a hub for integrating all of the services that

are provided and then what I call the big brother of the patient-centered medical home which is the accountable care organization which gets involved also in hospitalization and other services like that.

The impact of this, though, is important for us to recognize. What it's doing is shifting risk and I'm talking here about financial risk, from the payer to the provider, in exchange for increased flexibility. That is you will have more flexibility over how you are delivering care, but you are going to be at financial risk for the amount of care that may be required.

Also, there's going to be shared savings and incentives to improve quality, to manage costs, and to improve the customer experience.

Next slide, please.

Well, we are trying. There we go.

Okay. The next slide.

Back a slide.

>> All right. Well, what we are going to do here is you will have copies of slides. I will just keep moving along here. And talk about really the last issue which is what does all of this mean to recruitment and retention. The first thing is that outreach services will have to be covered by grant funds. And that is that all the outreach that you are doing is not going to be normally covered within any of the funding packages that are provided under an insurance benefit.

Secondly the screening and treatment will be covered by insurance for those who are covered by insurance, and in that regard, we get into the issue or the fact that there are individuals who are not going to be covered. Those will be the individuals in non-Medicaid expansion states who don't have insurance. That will also be those people who are undocumented, et cetera, and that's going to be increasing the population where we are going to have to be able to provide service -- medical services as well.

Third, there will be pressure to increase, to help foster the enrollment in insurance, in Medicaid expansion states. It's very, very clear that the role here is if your state has expanded Medicaid, we want to insure that everybody is covered. It provides the most comprehensive service package for that individual. It will also -- it also ensured that you don't have to use the precious grand funds to be able to cover those medical services.

The last thing is reimbursement for retention support services are going to be determined by each state, and what it

is, is that each state, as they design their Medicaid plans, are going to have to determine what type of retention support services they are going to be willing to pay for and what kind of integration of services they are willing to pay for. These are going to be critical issues that you are going to need no monitor within your own state and potentially even advocate for changes based upon what you think makes good common sense.

That is kind of totality in a very, very short period of what the Affordable Care Act does and how it works within things.

I would be glad to at any point in time that it's appropriate address questions. I will be around while the other presentations move forward.

>> ILZE RUDITIS: Excellent, so you will be with us for any discussion questions?

>> WILLIAM HUDOCK: Yes, I will.

>> ILZE RUDITIS: This is Ilze Ruditis, I wanted to give us another ill brief introduction from our three presenters from the grant sites. We wanted to illustrate the different types of scenarios that Mr. Hudock was talking about and how they have arranged themselves through the MAI-CoC utilizing the University of Colorado project, Sunrise in Los Angeles and also health services center in Anniston, Alabama. We did get a substitute at the University of Colorado. We will be hearing from Kelly Wilson and, of course, she's in an expansion state and they have a actually collocated and integrated services project.

Then in Sunrise, in Los Angeles, we will be hearing from David Salinas and California is an expansion state and their project is integrated but it's not collocated. And then finally, we will hear from another Kelly, Kelly Turner with Health Services Center in Alabama which we know is not an ACA expansion state. And their project is fully integrated and collocated also. So we have two expansion states. We have two projects that are collocated and integrated and one which is integrated, and not collocated.

With, that we would allow the presentation to be turned over to Kelly Wilson at the University of Colorado.

>> KELLY WILSON: Hi, everybody. Thank you so much for having me present today I'm from the University of Colorado Denver, addiction research and treatment services and we are on this project, project REACH, risk, education for at-risk communities on HIV/AIDS. We have been asked to talk about our retention and our engagement processes here.

We have been very fortunate and have been able to populate

and maintain the population of this project through several different ways. So first, I would like to tell you a little bit about us, ARTS as we are known as is addiction, research and treatment services. We have an evidence-based program model that fully integrated our treatment on the medical side, the substance use side and the mental health side as we have an on-site psychiatrist who does mental health evaluations. Our mission is to save lives for persons struggling with substance abuse through empirically supported treatments. We are focusing on our minority populations IV drug users people who are born out of the United States and historically have not had great access to treatment. Males who -- MSM population as well is one of our big populations that we are targeting right now for this project. And it seems to be going very well.

Our partners are an integral part of this project. We certainly couldn't do it without our partners out there in the community. Sisters of Color united for Education are known for delivering culturally grounded to hard to reach at-risk populations and have experience in adapting evidence-based program for use with the Latino population. We have a full-time peer educator, prevention and education and outreach specialist with Sisters of Color United For education who go out to places like bath houses and places in our community like the triangle to target our folks who would qualify for this project who haven't historically reached out for treatment themselves, and they spend a lot of time with folks, all of our peer educators with folks out in the community trying to engage them into the process.

And we find a lot that the first time we encounter folks they are not necessarily interested in coming in to treatment but when we are out there in their space, the third or the fourth time, they start to trust us and recognize us and ask questions about our services and become more curious and as their curiosity grows and we keep coming, we find that they then come into our project.

Another one of our partners is Harm Reduction Action Center. They promote public health by incurring that people who inject drugs are educated and equipped with the tools to reduce the spread of communicable diseases such as HIV and hepatitis C. They come into our clinic and provide hepatitis C 101 care and vein care and education, and drugs on the brain and stages of change education. We found that this partner is particularly helpful with our IV drug users and our Hispanic IV drug users as well as they provide some of these wraparound services. And they encourage them to come into their program outside of this

project to receive other services that are available to them and kind of integrate into the community of folks who are recovering and are working toward some more health and mental health goals.

Another partner on this project, we have is Advocates for Recovery. They are an organization dedicated to continue changing in the conversation for addiction to recovery. They are have taken on the peer educators and they can do the work that they can do. We find our peer educators are an integral and very, very important part of this project. They are the ones out there meeting with patients who really could benefit from this service and are either afraid to come into the service or didn't know it existed or didn't even know that they could have access to it.

And so our peer educators are very integral to this project and they receive ongoing suppressed vision and training as well from this partner agency.

And lastly, our Servicios de la Raza them provide services for many human service agencies and institutions in the metro Denver region as they encounter Latino clientele and they are specific to the Latino population. They will do some ongoing training with our peer educators specific to the Latino population as that one of our priority populations that we are focusing on this project.

Project REACH services include evidence-based -- recruitment, look at me. Recruitment comes out of our criminal justice system. To our Colorado department of corrections our treatment and recovery courts. We have got a lot of treatment courts in and around the Denver metro area and we have found that this particular population is very evident in our criminal justice systems, over represented in our criminal justice systems which gives us a good chance to tap into that system, and kind of integrate all of these services for these patients.

And we have had great success with that. We have criminal justice specific programming and things like that, that will also work with their criminal justice needs, recidivism prevention, all of that good stuff that will help them be more integrated with their healthcare and their mental healthcare and their substance use. We also tie in the criminal justice specific piece.

Outreach is another way we get a large amount of our participants again using our peer educators to do a lot of our outreach. We participated in a gay pride event as well. It was incredible. There were thousands of people there. We had

peer educators running around and talking to people, and passing out safe sex kits and high-risk persons were at the event that we participate in and we found that we have a lot of interest generated from those programs.

Again, there's a lot of times some skepticism on the part of people who want to be in treatment for various reasons. So these outreach events really give us a chance to reach them multiple times before they come into this program.

And then our community and project partners like I talked about earlier, are also an integral part of how we recruit people into this program and they are out there doing their thing and even if it's not a project REACH specific event that they are putting on, they are well versed in project REACH and the benefits of Project REACH and they say, why don't you go see our educators or peer counselors if they can benefit from the integrated services.

We have a lot of IV drug users as well who vet this population who have no other access to services and we have been able to utilize from Project REACH for them as well and able to provide them truly integrated care, sometimes for the first time in their lives.

Which has been extremely helpful.

Project REACH include substance abuse groups, and individual sessions, and methadone, and naltrexone, and any of those for alcohol or opiate dependence we provide here on site we have psychiatric we have dedicated slots with our psychiatric doctor to do full mental health evaluations and ongoing medication management with our patients involved in Project REACH. We found that was a critical piece that we did not see from the outset of this project because we were focused on integrating health care, health care, health care and the mental health, those at risk for infectious disease have a lot of mental health things that come along with that. We were finally able to integrate our psychiatric care which has truly helped us with our retention of these folks.

We also have coordination of medical care, through medical case manager who works with our medical staff not only in house but the University of Colorado infectious disease center, as well as our partners and works with our counselor and our peer educator so that everybody is on the same page and we are ensuring our participants are getting the best possible well rounded medical care that they can. If we don't have that particular service on site, we provide transportation assistance in order to get the patient where they need to go for that particular service.

That ties to our referral for outsized medical service. If we can't do it in house, we do is to that our participants can get to that service. Our peer educators we talked about and that's such an integral part of our this process and the retention of the patient and the engagement of the patients from the outset. We have culturally specific for the partner group, for the various cultural populations including trauma groups for men and women that are separated out, risk reduction groups as well, and mi vidasu vida. And peer groups. They can come and meet with the peers just for support and they can put their concerns out on the table whether it's substance use or medical or personal or any of that and just get support from people who understand and can support that.

Abstinence monitoring, part of game. We do that as well. We want to ensure that everybody in this program that, we are working towards abstinence with and we are monitoring any drug or alcohol use that happens. As we know that directly affects to their medical and psychiatric care as well. So as a team, we talk about some of those UA results and BA results to make sure that we are all on the same page and providing the best possible care for our patients.

Infectious disease testing is a huge part of this as well. We have the tightest testing and the HIV testing and we are using the third generation HIV testing at this site. And allowing participation and testing and then ongoing testing if somebody has a negative and feels like they would really like to be tested again that's something that we can offer in house through our partners and through the infectious disease center. Other infectious disease testing, the hepatitis testing and we are working in other infectious disease testing into the projects now, things like chlamydia, gonorrhea, and other testing that patients have requested from us, is there any way we can do this too, and we are utilizing our partners now to include that as part of our programming.

And then hepatitis vaccination we do as well. And we are finding that people are buying into that a lot when there's some fear about being tested in the first place, and somebody has a negative result, offering that vaccination is very comforting and very helpful that we have found.

So retention. Once we got 'em here, we are finding that we are able to keep them nor many reasons. We have a safe and welcoming environment. We have treatment on equal basis with others, free from discrimination because of race, religion, sex, age, ethnicity, disability, sexual orientation and gender expression which is written very clearly at the pop of our

patient rights and posted in every single clinic. We have a quality signage displayed in all group rooms and therapy rooms, lobbies and entry doors. We have a very diverse staff, not only on this project but in the agency as a whole. We reflect the faces of our patients, so they feel comfortable in to speaking to them. We are conveniently located in the metro area along major rapid transit lines and that helps as well, while we do provide transportation assistance, us about passes and us about tickets if we were not off a bus line we would have a difficult time retaining our patients because they have a hard time getting to us. It's hard enough to get around on public transportation and so westerly right off of a bus stop which is very helpful.

We are close to the judicial, the department of services and other major hospitals, including our hospital and our infectious disease center. So the location is key. Which ties to our treatment accessibility. The clinic that this project is housed out of is open 13 hours a day, four days a week and then also open the other days a week for reduced hours. And so we have really found that with our 7 a.m. to 8 p.m. workday along with some weekends that we are really able to cater for those folks who are working, who have medical services during the day, who have judicial obligations, that they need to comply with as well. So I think that accessibility has been very helpful.

And then, of course, our evidence-based practices we use groups straight from the NWRAP catalog and the evidence-based practices and the support services including the peer educators our peer run groups and the pro social events, which utilize the community free day like the zoo when it's free and the museum when it's free and we utilize those and take this group of folks for a pro social event and then, of course, the core nation of care with our -- coordination of care with our medical and the substance use treatment team and our behavioral and psychiatric team as well.

>> ILZE RUDITIS: Okay. Thank you. Hi. Thank you. Kelly, that was a very thorough overview.

>> KELLY WILSON: Thank you.

>> ILZE RUDITIS: We have about 10 minutes to each of you, we will have ten minutes for questions. I wanted to be sure that David Salinas is with us with sunrise community counseling center.

>> JAKE BOWLING: Hello, David, can you hear us?

>> Yes.

>> ILZE RUDITIS: Thank you.

>> JAKE BOWLING: Is David Salinas on the line?

>> ILZE RUDITIS: Thank you. Thank you, go right ahead. We are having trouble with our mute button here. Thank you. Go right ahead.

>> JAKE BOWLING: Ilze, this is Jake with CIHS, I was asking David if he was on the line. We haven't heard him yet.

>> ILZE RUDITIS: Okay. He is on the line.

>> JAKE BOWLING: All right.

>> ILZE RUDITIS: And we are hearing him here.

>> JAKE BOWLING: Oh, okay.

>> ILZE RUDITIS: David said hello. Didn't he? Oh, that was just you?

>> JAKE BOWLING: Yes, probably so. So --

>> ILZE RUDITIS: Are you reaching out to him?

>> JAKE BOWLING: Yes, we are connecting with him now to check out his audio. Do you want to move forward with the next presenter, with Kelly, while we are work with him?

>> ILZE RUDITIS: Sure, if she's here, yes, of course.

>> KELLY TURNER: Yes, I'm here.

>> JAKE BOWLING: Hi, Kelly.

>> KELLY TURNER: How is everyone.

>> ILZE RUDITIS: Okay. So Kelsey from Anniston, Alabama, in a non-ACA expansion state, but collocated and integrated in their project site. Thank you.

>> KELLY TURNER: Hello, good afternoon, everyone. Okay. I'm just going to talk about this afternoon, some recruitment and retention strategies that we use here in the rural South. I'm trying to advance my slide. There we go. The target population that we serve for our behavioral healthcare program, also known as BHC, we like to focus on under served populations in our area, which are persons of color, LGBT populations and women. We also prioritize veterans with this program as well.

The grant goals and prevention and testing are to do 300 HIV tests a year and 500 screenings for viral hepatitis C disease. We have a goal of enrolling a minimum of 75 persons annually into our evidence-based outpatient substance abuse treatment program and we also have mental health services available during these treatment programs. We have a behavioral navigator on our program that we will talk about in the next slide and this --

>> ILZE RUDITIS: I think you are leaning into your mic. We think you are leaning into your mic so if you sit back just a little bit.

>> KELLY TURNER: Sure, how is this?

>> ILZE RUDITIS: That's perfect.

>> KELLY TURNER: I think what happens is I may have had my finger over where I was trying to speak.

>> ILZE RUDITIS: Okay.

>> KELLY TURNER: Okay. We have a behavioral navigator in this program, and this individual helps maneuver this project for us. She helps people who test positive for hepatitis C to be navigated into healthcare and sometimes that is immediately, and that's one of the things that I will talk about in just a moment that we do well. The first thing that works for us is our hard working and dedicated staff. I cannot say too much about this staff on this project. We have two behavioral health counselors. One focuses on substance abuse treatment and that program, the 75 individuals. We have another behavioral health counselor who focuses on the mental health assistance and he works closely with our psychiatrists here at the center.

We have' behavioral health navigator. She has a degree in social work and so she's a case manager in that she helps with our testing events and then helps folks move into treatment and then assists them with things that they may need enrolling into Medicaid, Medicare, helping them with housing employment, all kinds of things in that area that is just constantly in demand in this area.

We have a driver and a toxicology technician. He is much more than that. He absolutely will provide transportation for each of our participants in the substance abuse treatment program. He will also come and help with our clinics and bring patients to their medical appointments, but he does more in the realm of intakes. He helps us with our drug screens and he also does our classes on nutrition and healthy lifestyles. He helps them learn how to -- just little things, how to dress in an interview, how to present yourself, things like that.

So he's much more than just the driver and toxicology technician.

We also have a prevention education specialist who coordinates testing events around our area and works closely with the behavioral health navigator to bring in new positives. There are many days that we have someone who tests positive, and the behavioral health navigator will speak with our nurse practitioner and the nurse practitioner will say bring them in today. And that's something that we feel like we do very well, because how often do you get to meet with someone for your medical care the very day that you test positive?

So we are -- we are very excited to be able to offer that on most days here.

Another thing that works well for us, we have excellent relationships with our referral sources. Our behavioral health navigator and case managers and other programs attend drug court on a monthly basis. They help to stand up for the clients that we have already participating in our substance abuse treatment programs, and they help to recruit new folks who have -- they are appearing in court for the first time and they can speak with the judge and saying we have this free program that can be offered to this person and a lot of times they will choose us instead of jail or other programs that charge, where we are very grateful to be able to offer our services for free.

We had referrals within our organization from our medical team to our housing department to our prevention department and also from our case management department. We receive referrals from all those different areas. We get referrals from local hospitals in our area, we call them to do state assessments and we happily go and do those. We are able to recruit patients to come and be a part of our program here.

We have community advocates with our health departments. We have everything from advocates in health departments, to churches, to community crisis centers, all of those things -- all of those places offer us referral sources and referral. They offer participants for our group. I'm sorry I'm playing with my phone here.

We also get client referrals as well, patients who have gone through the program will refer their friends who are struggling with some of the same substance abuse issues. They say, hey, why don't you try this program and so we will get them in and when we talk about how they were referred to our program, they will say, oh, so and so who has already been through the program speaks highly of you and of your staff. And, again, with this staff that I have here, I'm not surprised if anyone paying them a compliment.

We also have client-centered treatment. This is another thing that we feel like we do well. The patients and the clients here participate actively in setting their goals. They help laid group sessions. They will be in charge of a group discussion when we first begin our program. We have what is called the therapeutic community, our patients and clients here lead that group. So that helps with our retention.

They want to come back because it's my week to be in charge of therapeutic community or, you know, when you are actively involved in your treatment planning, you own that. It helps our clients want to continue to be a part of this program.

During our clinical sessions, our clinic times for HIV and HCV, we have support groups that we have started. Those for the newly diagnosed with HIV or hepatitis C are able to participate while they are waiting on the doctor in a support group, and it is -- they are able to see kind faces of staff. They are able to see kind faces of peers who have been where they are, and can help them to understand, you know, what to expect, their first few weeks, their first few appointments, and it helps them to have a smoother transition into care here.

We offer our treatment groups in two different cities, at different times. We feel like this helps as far as the clients' schedule. We are flexible in helping them get into the group that best fits their time schedule, if they have a job, we want them to continue to keep their job, to be able to keep working and also be able to get the benefits that we offer.

So we are flexible with our times, and that's another thing that we feel like is working well for us.

The main thing about client centered treatment, it's about establishing relationships with our patients and our clients that come through the door. They need to see a kind face when they walk in the door. They need to see a kind face when they are receiving their test results. They need to see a kind face when they are working through their treatment planning and the treatment goals and we are able to provide that for them have this relationship with them where they feel comfortable in sharing and comfortable in taking part and being active in their recovery and in their treatment.

Overcoming challenges, we are in the first year of the grant. So we don't -- we are not as close to the number of tests that we wanted to provide as far as hepatitis C. and the number of clients that are enrolled into substance abuse but we feel like we are going to hit those goals before September 30th. Next year, when we are fully operational for an entire year, we would probably have to work not to go over our numbers. So I feel like that's kind of been a challenge as far as the first year of the grant. Several referred clients and retention, that can be an issue when you do not have the criminal justice system giving you that gentle push. You know, I'm kind of kidding with that, they are required to come. When you don't have that, sometimes you are not as motivated to continue to come. So that is why we have focused so much on this client-centered treatment, because if you don't have a referral source that is, you know, giving options, you know, you need to do this you need to complete this. We need to come in and do

that in order to have that retention.

We also have limited mental health services. We can provide mental health services, if you have sincere mental health services that requires immediate attention we must refer out. So there's a long waiting list for a lot of these community mental health organizations and so we have to try to hold their hand until they can get there, and keep them coming and active in treatment, but if they are struggling severely with mental health issues we feel like there's such a waiting list that sometimes that's very difficult for them.

Those challenges I feel like we can work with in the years to come and continue to make those mental health referrals and keep our name available for those services and they will know, you know, that we are here and we are still establishing those relationships, and we feel like we will be able to make those relationships as good as the ones that we have with our outside referral sources.

Thank you all very much. That is our presentation.

>> ILZE RUDITIS: Thank you. A wonderful overview of your work in rural Alabama in a non-expansion state.

Thank you so much.

Is David -- I think that you are now going to be off mute on your own phone. Are you still with us? Can we check in with David Salinas?

>> JAKE BOWLING: Yes, this is Jake Bowling. We are checking in with David now. If you will just give us a few seconds.

>> ILZE RUDITIS: He's been corresponding with you.

>> JAKE BOWLING: Yes, he has. Perhaps -- oh, did someone join us? So perhaps while we're waiting on David's audio, do folks have a couple questions we can offer to the previous presenters or to Mr. Hudock at SAMHSA? Feel free to type those questions in the chat box.

>> ILZE RUDITIS: This is Ilze.

>> DAVID SALINAS: Hello, this is David. I was using my phone, but it doesn't work so I called in via another phone. Okay. So I'm here. Thank you, everybody, for your patience.

>> ILZE RUDITIS: No problem, thank you, David.

>> DAVID SALINAS: Great. My name is David Salinas. And I'm one of the program coordinators for the sunrise community counseling center. We are in the boundary of service planning area 4, which is west of downtown LA in the West Lake Neighborhood.

Sunrise counseling center is a nonprofit center that has been serving the community of Los Angeles since 1976, providing low-cost substance abuse and mental health services along with

free HIV testing. All of our counselors are trained and certified in proven evidence-based programs and practices and are able to deliver services in a culturally sensitive manner in the larger Hispanic Latino population in the surrounding areas.

We have our Proyeto Buena Vida. Our program services include 12 weeks of individual and group CBT sessions along with HIV, and hepatitis c and hepatitis A and B vaccination and an additional 12 weeks of assertive continuing care reinforcement approach model. We provide case management for all of our participants, linking them to their needed services.

Proyeto Buena Vida has been able to provide medical services. We provide all the HIV and viral hepatitis screening and hepatitis A and B vaccination and AIDS healthcare foundation provides all HIV treatment and care.

Proyeto Buena Vida to date has recruited 55 clients. Our target goal for this year was 50 clients so we have reached our golden exceeded it. The majority of our participants are white Hispanic, some participants include black Hispanic, black non-Hispanic, although the majority of participants identify as heterosexual, a few identify as gay, lesbian or bisexual. Women make up 52% of the gender split.

The success of recruitment has been close -- is largely due to Sunrise's good relationship with the LA courts. We have constant communication with social workers and probation officers about all the programming, including federal programs like Proyeto Buena Vida. Several of our referrals have come from the department of child and family services for parents with substance abuse and mental health issues as well as from criminal courts.

Sunrise also has a strong presence in the community. We are part of the MacArthur Park Neighborhood which includes community residents and the Westlake Coalition which is the city of LA, and the St. John's Hospital and some of the activities that we provide include health fairs, community outreach and community assistance. We also work closely with the Mexican consulate, which puts on many health fairs throughout the year focusing on community health and, again, our presence in the community has been key for recruitment.

What keeps participants coming? Well, the fact that we offer free services is a key fact in having participants come.

A large proportion of residents in this service areas live in poverty and behavioral health services are often out of their reach, due to their economic situation.

We also have culturally sensitive and experienced staff,

which pay very close attention to the participants' backgrounds be it their country of origin, their sexual preference or the socioeconomic situation. We are also centrally located and easily accessible by foot, bicycle, bus, metro, car, anyway, and we have varied hours of operation, including evening hours and week weekends. That's Saturday and Sunday. This works because most of our work, most of our participants have other -- other priorities like work. So when we are not able to make it during the day, we can -- we have open hours in the evening, and on the weekends.

What makes it hard to keep participants coming? Work schedule conflicts is probably the primary reason why people stop coming or can't make it to their sessions. Some participants are employed but many have work which they prioritize over counseling. The lack of child care, moms without a good support system often have trouble finding child care and find it difficult to come to our counseling when they have their children to take care of.

Although we are easily accessible, we have many routes and they are over your appointments and they have many commitments and become overwhelmed with all the traveling they have to do. Especially when they depend on public transportation.

Loss of interest is another factor. Some have voiced their loss of interest because they have other things going on in their lives and as the next point says, they change priorities and, again, prioritize other activities, especially when they are court ordered to engage in other programs and find it very overwhelming to go to all the programs and still keep employment.

Finally, the level of care needed, once into the session still becomes apparent that some participants need the higher level of care, especially with those with substance abuse. Those participants need to be referred out and so they stop coming. They become incompleters in our program. Those are the main challenges that we face here at Sunrise Community Counseling Center. That's it. Thank you very much.

>> ILZE RUDITIS: Thank you. That was excellent presentation. We're coming up to the break time. So I'm wondering if I could suggest that we use the chat box to end us a couple of questions and also to continue to use it so you can exchange thoughts about these presentations. I know that you saw yourself or part of yourself or some part of yourself that you used to be in these presentations. And they are very rich with context and the variety of approaches to doing this work in recruitment and retention.

So I'm not sure that see any questions to this session right now.

What I would like to do is turn it back to Jake. At the end of the day, we will have a session called stop, start, continue and so you might keep in mind things that you have heard and as you continue learning this afternoon, things that you in your projects may wish to stop, start, or continue and I think Jake will orient you to how to get to your breakout and also how to reconnect for the closing session at the end of your workshop.

Thank you.

>> JAKE BOWLING: Thank you, so much, Ilze. Now it's time for a short break from 3:15 to 3:30. At 3:30, the concurrent breakout sessions will take place and so in order to access your breakout session, you will stay within this classroom. So you don't want to close out this window.

What you will need to do, however, is to hang up your phone or if you are joining through your computer mic, you should end your audio in this session. And then instead, call in to the various conference lines that are listed under the notes panel on the bottom left-hand side. Your screen. So you will see the breakout listed in the notes panel, and they all have a corresponding conference line number, as well as a link to click on if you would like closed captioning for that breakout session.

At 4:30, as Ilze said, we will return to the main classroom, and that will happen automatically, after your breakout session ends and the host ends your breakout session, you will automatically be filtered back into the main classroom, but you will want to call back into the main line, the way that you did this morning to get on.

Since there will be some grantee discussion at the end of the day, it may be a good idea to use your phone instead of using your computer mic and speakers. Some of the audio issues we had this morning are related to using computer mics which send to be a little less reliable than using your land line or cell phone.

So with -- oh, also I wanted to make you all aware, yesterday Gigi Summerville, who is the branch chief for SAMHSA did offer a weekend on behalf of SAMHSA and some remarks. On the file share section of your display panel, you will see the third file down that says "Somerville welcome day one" so she's been kind enough to write out her remarks since they were audio issues yesterday. So please review those. They are very nice and very helpful.

So at this time, stay on the -- stay in the video session.

You can hang up your phone and in about 15 minutes, your breakout sessions will begin.

Thank you so much.

(Break)